WESTERNPATHOLOGYINC.COM
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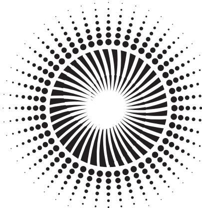
WESTERN PATHOLOGY



FOR INTERNAL USE ONLY
PLACE LABEL HERE

TEST REQUISITION ORDER FORM

ORDERING PROVIDER INFORMATION	PATIENT INFORMATION
	DATE OF SERVICE / MEDICAL RECORD NUMBER
	FIRST NAME / MIDDLE INITIAL / LAST NAME
	DATE OF BIRTH / GENDER
	ATTACH PATIENT DEMOGRAPHICS AND INSURANCE CARD(S)

SELECT BILL TO RESPONSIBLE PARTY:	REQUIRED Workers' Compensation Information:
☐ INSURANCE	Claim Number:
☐ PATIENT	
☐ ORDERING PROVIDER	Date of Injury:
☐ WORKERS' COMPENSATION	

PATIENT RECORDS AND/OR IMAGES ARE APPRECIATED
☐ ***Records Attached*** ☐ ***Images Available/Attached***

ICD-10 OR NARRATIVE DIAGNOSIS

ICD-10# **ICD-10#** **ICD-10#**

EACH SPECIMEN CONTAINER REQUIRES TWO PATIENT IDENTIFIERS

PREVIOUS PROCEDURE(S)

Date of Service: ____ / ____ / ____ Accession Number: ____________________

Date of Service: ____ / ____ / ____ Accession Number: ____________________

CONSULTATIVE SERVICES

☐ Slide(s) for Consultation ☐ Block(s) for Consultation

SPECIMEN SITE(S)	PROCEDURE(S)	SPECIMEN ID NUMBER(S)
	☐ Shave ☐ Punch ☐ Excision	
	☐ Shave ☐ Punch ☐ Excision	
	☐ Shave ☐ Punch ☐ Excision	
	☐ Shave ☐ Punch ☐ Excision	
	☐ Shave ☐ Punch ☐ Excision	
	☐ Shave ☐ Punch ☐ Excision	

CLINICAL HISTORY AND/OR HISTOLOGICAL IMPRESSION

WPI001 (01/21)

TEST REQUISITION ORDER FORM COMPLETION AND PROVIDER SIGNATURE ARE REQUIRED FOR SPECIMEN PROCESSING

Ordering Provider Signature ______________________________ Date: __________

Patient Signature ______________________________ Date: __________

LABORATORY

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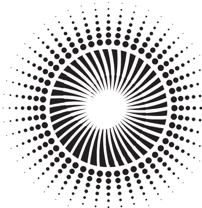

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PROVIDER COPY